AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
To: PEDIATRIC ASSOCIATES OF STOCKTON

This authorization allows the release of confidential medical information & records.

I hereby authorize:

_____

_____

_____

to release information to ***Pediatric Associates of Stockton*** regarding medical history, illness, injury, consultation, prescriptions, diagnosis, treatment, including x-ray and lab reports, and any other records sent to us from outside physicians, hospitals, clinics, etc.

This authorization is:

[ ] Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis and treatment

[ ] Limited to a specific visit ____/_____/____ or the immunization record only.

[ ] Limited to financial information for date(s) _____.

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)

Psychiatric/Mental Health _____ (initial)

Tests, diagnosis, & treatment for HIV _____ (initial)

Genetic Information _____ (initial)

Duration: This authorization shall be effective immediately and remain in effect for 60 days from the signature date below.

Restrictions: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained unless such disclosure is specifically required or permitted by law.

A photocopy or faxed copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of patient or legal/personal representative Relationship to patient

_____ ___/_____/_____ _____/_____/_____
Patient's Name (PRINT) Patient's Date of Birth Today's Date

_____ _____
Witness Name Witness Signature